

Date: [Date]

Referring Physician: [Name of Referring Doctor]

Primary Care Physician: [Name of PCP]

RE: [Patient Full Name]

DOB: [Patient Date of Birth]

Dear Dr. [Referring Physician Last Name],

Thank you for referring [Patient Name] for an interventional pain management consultation regarding suspected sacroiliac (SI) joint dysfunction. I had the pleasure of evaluating the patient today.

Chief Complaint:

The patient reports [Duration] of persistent pain localized over the [Left/Right/Bilateral] sacroiliac joint. The pain is described as [Description: aching/sharp/dull] and radiates to the [Buttock/Groin/Thigh]. Symptoms are exacerbated by [Triggers: sitting, standing, or walking].

Physical Examination Findings:

On examination, there is point tenderness over the PSIS and the SI joint sulcus. The following provocative maneuvers were positive:

- Gaenslen's Test: [Positive/Negative]
- FABER Test: [Positive/Negative]
- Compression/Distrraction Test: [Positive/Negative]

Neurological exam of the lower extremities remains intact.

Imaging Review:

[X-ray/MRI/CT] dated [Date] demonstrates [Findings: e.g., degenerative changes, sclerosis, or no acute pathology].

Assessment:

[Left/Right/Bilateral] Sacroiliac Joint Pain (ICD-10: M53.3).

Plan:

Based on the clinical presentation and physical findings, I have recommended a **Fluoroscopically-Guided Sacroiliac Joint Injection**. This procedure will serve both a diagnostic and therapeutic purpose. We will utilize a combination of a local anesthetic ([Drug Name]) and a corticosteroid ([Drug Name]) to reduce inflammation and confirm the pain generator.

The risks, benefits, and alternatives have been discussed with the patient, and they wish to proceed. The procedure is scheduled for [Date]. We will follow up two weeks post-procedure to assess the degree of symptomatic relief.

Thank you for the opportunity to participate in this patient's care.

Sincerely,

[Your Name, MD/DO]

[Practice Name]

[Contact Information]